Section 1: Who's Who in Medicaid

What Is Medicaid?

Title XIX of the Social Security Act (Medicaid) is a medical assistance program administered in North Carolina by the Division of Medical Assistance (DMA) for certain low-income individuals and families. DMA contracts with Electronic Data Systems (EDS) to process Medicaid claims for payment and to perform administrative tasks.

Eligible recipients receive medical care from providers enrolled in the program, who then bill Medicaid for services. Updated coverage information and changes are issued in monthly Medicaid bulletins and through provider visits and seminars. Medical coverage information and Medicaid bulletins are available on DMA's Web site at http://www.ncdhhs.gov/dma/prov.htm.

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that regulates and oversees all state Medicaid programs. In addition, CMS is responsible for enforcing the transactions and code-set standards that are part of the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Department of Health and Human Services

The N.C. Department of Health and Human Services (DHHS) oversees the administration of numerous health care programs in the State of North Carolina, including Medicaid.

Division of Medical Assistance

The N.C. Division of Medical Assistance (DMA) is the state agency that administers the N.C. Medicaid program by

- Interpreting federal laws and regulations as they relate to the Medicaid program
- Establishing clinical policy
- Establishing all fees and rates
- Establishing provider enrollment requirements
- Maintaining provider files
- Maintaining third-party insurance files
- Maintaining the Eligibility Information System (EIS)
- Enrolling all qualified N.C. Medicaid providers
- Administering Medicaid managed care programs
- Publishing clinical policy
- Publishing Medicaid bulletins

Department of Social Services

Each county department of social services (DSS) is responsible for

- Determining recipient eligibility for Medicaid
- Enrolling recipients in managed care programs
- Maintaining all recipient eligibility files

- Providing adult care home (ACH) enhanced care prior approval and case management services

Electronic Data Systems

Electronic Data Systems (EDS) is the fiscal agent contracted by DMA to

- Process claims for enrolled Medicaid providers according to DMA's policies and guidelines
- Establish and maintain a presence with the Medicaid provider community through
  - Provider seminars
  - On-site visits to providers for assistance with billing issues

Division of Medical Assistance: Organization Roles

DMA is the state agency responsible for the administration of the N.C. Medicaid program. DMA is organized into seven administrative sections with responsibilities as outlined below.

Recipient and Provider Services

The Recipient and Provider Services section is responsible for establishing recipient eligibility policy and maintaining the Eligibility Information System. This section is also responsible for provider enrollment, claims analysis, time limit overrides, and provider education. This unit works closely with EDS provider services and monitors activities such as seminar planning, provider visits, and Medicaid bulletins. DMA field staff provide management consultation and technical assistance to county DSS staff and are responsible for training DSS staff on eligibility and EIS issues.

Clinical Policy and Programs

The Clinical Policy and Programs section is responsible for the overall administration of programs and clinical services covered by the N.C. Medicaid program. The Clinical Policy and Programs section establishes policies and procedures for the provision of all Medicaid-covered services and provides prior approvals for some Medicaid procedures and services.

Policy Development and Special Projects

The Policy Development and Special Projects unit is responsible for

- Facilitating rule-making activities and Medicaid State Plan amendments
- Ensuring that clinical coverage policies are developed in compliance with GS 108A-54.2, including
  - Obtaining the advice of the N.C. Physician Advisory Group
  - Following a prescribed process for seeking provider and public comment on proposed policies
- Reviewing and updating clinical coverage policies based on changes in medical and dental practice and literature
- Evaluating policies for efficacy, fiscal impact, utilization, and population analyses
- Monitoring, analyzing, and evaluating Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy and the day-to-day operations associated with the EPSDT program, including claims adjudications and stakeholder education

- Monitoring, analyzing, and evaluating due process policy and the day-to-day operations associated with the due process program, including stakeholder education

Practitioner and Clinical Services

The Practitioner and Clinical Services Unit is specifically responsible for the service areas that include, but may not be limited to, physicians, chiropractors, nurse practitioners, nurse midwives, podiatrists, ambulatory surgery centers, rural health centers, federally qualified health centers, health departments, certified registered nurse anesthetists, anesthesia services, laboratory and radiology services, Family Planning Waiver, ambulance, outpatient hospital services, end-stage renal disease services, hysterectomies, sterilizations, abortions, obstetrical services, child services coordination, maternity care coordination, childbirth education, and health and behavior intervention.

Pharmacy and Ancillary Unit

The Pharmacy and Ancillary unit is responsible for the following:

- Ensuring compliance with the Pharmacy Outpatient Program by developing clinical coverage policies according to national or evidence-based standards
- Ensuring compliance with the durable medical equipment (DME) and orthotics and prosthetics (O&P) policies, hearing aid services policy, optical services policies, the local education agency policy, the physician drug program policy, the independent practitioner policy, and the outpatient specialized therapies policy
- Routinely reviewing and updating clinical coverage policies based on changes in clinical practice and literature
- Evaluating policies for efficacy, fiscal impact, utilization, and population analyses

Managed Care

The Managed Care section is responsible for the administration of the Community Care of North Carolina (CCNC) program [Carolina ACCESS (CA) and ACCESS II/III]. Refer to **Managed Care Provider Information** (Section 4) for additional information on managed care providers.

This activity includes

- Developing and implementing managed care policy
- Recruiting and educating providers to participate as primary care providers (PCPs)
- Furnishing technical assistance to providers
- Assisting the medical community to understand managed care programs
- Developing ACCESS II/III in conjunction with the Office of Rural Health and Community Care
- Monitoring contractual compliance
- Staffing the Customer Service Unit

Quality, Evaluation, and Health Outcomes (TP)

The Quality, Evaluation, and Health Outcomes Unit (QEHO) ensures compliance with federal requirements regarding quality, accessibility, and efficiency of care provided within the Medicaid program and researches opportunities and strategies for cost-effective and quality-based service delivery. In addition, QEHO supports Community Care of North Carolina (CCNC), certain waiver programs, and other activities including:

- Performance improvement quality initiatives
- HEDIS/utilization and other benchmark reporting
- Clinical focused care studies
- Quality improvement support
    - Identification of redundancy and opportunities for efficiencies
    - Review of current data use
    - Needs assessment
- Piedmont PIHP (Prepaid Inpatient Health Plan) quality-related contract compliance monitoring
- Piedmont PIHP waiver development and maintenance
- Waiver tracking and proposal evaluations
- External quality review of Piedmont PIHP
- National Provider Identifier (NPI) activities
- Support for CCNC efforts
    - Focused study data at the CCNC network level
    - Data support
    - MMIS report and systems development

Piedmont Cardinal Health Plan

If the recipient is enrolled in the Piedmont Cardinal Health Plan, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" is printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed.

Finance Management

This section comprises Rate Setting, Hospital Reimbursement, and Audit organizations. Activities and responsibilities are as follows.

Rate Setting

The Rate Setting unit is responsible for establishing and maintaining reimbursement policy and payment rates for all Medicaid providers and payment programs (with the exception of hospital providers) and calculating the fiscal impact of proposed and approved rate changes.

Hospital Reimbursement

The Hospital Reimbursement unit is responsible for establishing and maintaining reimbursement policy and inpatient/outpatient payment rates to hospital providers, as well as for administering the Disproportionate Share Hospital (DSH) payment program.

Audit

The Audit unit is responsible for settling costs and auditing cost reports from various provider types and organizations, including long-term care, hospital, federally qualified health clinics, rural health centers, and local health departments.

Budget Management

The objectives of the Budget Management section are to accurately project category-of-service expenditures by category of eligibility, changes in eligibility, and the rate of consumption of units of services. Because the DMA budget is the largest budget in DHHS, it has high visibility in the Department as well as throughout the whole state. A 1% error in projections regarding the total

budgeted requirements could create an impact of up to $103 million. This section responds to and prepares all fiscal analyses requested by the General Assembly when considering reduction or expansion options for the biennial budget. This section has responsibility for documenting the Medicaid forecasting model, performing trend analysis on key factors driving the Medicaid budget, researching and developing data to support decision-making on budget assumptions, and producing multi-year forecasts.

Much of the business of the Medicaid and N.C. Health Choice for Children programs is conducted through contractual agreements, including multiple contracts with the same provider. Total contract expenditures are expected to reach $60 million this year. Budget Management is responsible for ensuring that adequate and reasonable payments are made to medical providers on behalf of the Medicaid-eligible clients. This section forecasts the budgetary requirements of the program to ensure that federal, state, and county funds are available to support program payments; maximizes the use of revenues; and approves all financial policies. All contracts and agreements with outside vendors are developed, approved, maintained, and monitored by this section.

The Budget Management section works closely with the fiscal intermediary to resolve provider and payment issues. This section creates the annual checkwrite schedule in conjunction with the DHHS Controller's Office and the fiscal agent. They also correspondend with providers who have questions about or issues with payments.

This section ensures that all general accounting functions are maintained. Besides vendor payments for general operating expenses, this includes accurate financial analyses and reporting as set by generally accepted accounting principles, the State Auditor, and comprehensive annual financial reporting guidelines established by the State of North Carolina.

Program Integrity

Program Integrity (PI) ensures that

- Medicaid dollars are paid correctly by identifying overpayments to providers and recipients occurring due to error, abuse, or fraud.
- Overpayments are recovered and the proper agencies are informed of any potentially fraudulent actions.
- Recipients' rights are protected and recipients receive quality care.
- Problems are communicated to appropriate staff, providers, or recipients; corrected through education and changes to the policy, procedure, or process; and monitored for corrective action.

PI achieves this by

- Conducting post-payment reviews of
  - Provider billing practices
  - Claims paid by the fiscal agent
  - Recipient eligibility determinations and targeted reviews
- Identifying overpayments for recoupment
- Identifying medical, administrative, and reimbursement policies or procedures that need to be changed
- Educating providers on their errors
- Assessing the quality of care for Medicaid recipients
- Ensuring that Medicaid pays only for medically necessary services

- Identifying and referring suspected Medicaid fraud cases to the Attorney General's office, Medicaid Investigation Unit, other state agencies, professional boards (e.g., boards of pharmacy, dentistry, etc.) or federal agencies for investigations